House Ways and Means Committee
Oversight Subcommittee Hearing on
"Improving Efforts to Combat Health Care Fraud"
March 2, 2011

Statement for the Record

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Introduction

We are writing to provide formal comments related to the House Ways and Means Committee Oversight Subcommittee hearing scheduled on Wednesday, March 2, entitled, "Improving Efforts to Combat Health Care Fraud." Apria Healthcare is a national provider of home respiratory, specialty infusion therapy and medical equipment services with a long history of serving both Medicare/Medicaid and commercially insured patients across the United States. With over 11,500 employees and 500 locations, Apria serves over two million patients' homecare needs annually throughout all 50 states. Accredited for all service lines for over 20 years, Apria Healthcare was the first provider of durable medical equipment and respiratory services to voluntarily seek and obtain accreditation.

With a comprehensive corporate compliance program in place for over a decade, which incorporates the Health and Human Services Office of Inspector General's (HHS/OIG) Guidelines for Healthcare Organizations, Apria has been a leader in strengthening the industry's overall compliance and anti-fraud and abuse efforts. For example, Apria has used its longstanding experience to offer specific recommendations to both Congress and the Centers for Medicare and Medicaid Services (CMS) and to lead the development of new, comprehensive Codes of Ethics for the two primary trade associations dedicated to the DMEPOS and home infusion segments of homecare.

Anti-Fraud and Abuse Efforts Play Key Role But Current Investments Are Misdirected

Apria strongly agrees with the need to reduce the amount of fraud, waste and abuse in the healthcare system and to prevent such fraud from occurring in the first place. We also recognize that audits and fraud investigations are integral components of the government's efforts to ensure that claims are properly paid. Apria has therefore been extremely troubled by the recent auditing trend, which has unduly targeted legitimate providers, has been highly inefficient, inconsistent and administratively burdensome for both providers and the government, has impermissibly applied new auditing standards retroactively and has completely lacked transparency.

We refer specifically to auditing efforts through what is known as Medicare Zone Program Integrity Contractors (ZPICs). Over the last eight months, Apria has received over 5000 individual line-item audit requests, which represents triple the volume compared to the eight months prior. In the case of two of Apria's Florida facilities, the ZPIC in question sent out individual requests (an envelope containing three pages) for each of 1,500 dates of service – totaling over 4,500 pages or nine reams of paper just for two moderately sized branch locations. While multiple dates of service in question were for the same patient, the ZPIC did not request one set of paperwork pertaining to all dates of service for that particular patient. Instead, the ZPIC required Apria to submit individual responses for each date of service, resulting in our having to repeatedly submit all of the paperwork necessary to substantiate the claim for each date of service.

Incorrect Data Calculations and Error Rates Submitted to Congress

Especially troubling are the incorrect conclusions and error rates being calculated by the ZPIC, which are ultimately reported to the CMS Durable Medical Equipment Medicare Administrative Contractor (DMEMAC), CMS and Congress, and the questionable data requests being made by ZPIC auditors. Regarding the first point, the ZPIC reported to one of our branches that it had a 100 percent error rate, based on only six dates of service out of hundreds that had been requested and to which we responded on a timely basis, five of which the ZPIC incorrectly alleged that the paperwork hadn't been submitted. Examples of the questionable data requests made to one of our Florida branches include on-site inspectors requesting photographs of all of the Medicare patients we serve and a list of our current and ex-employees' Social Security numbers. No auditor in the history of Medicare audits has ever requested photographs of patients and no regulation requiring providers to obtain photographs of home-based patients exists, not to mention the fact that such a practice would potentially violate the government's own federal regulations concerning patient privacy (Health Insurance Portability and Accountability Act (HIPAA)). The on-site auditor commented verbally that it was clear that we operated a legitimate location which was properly licensed by the State of Florida, included a real warehouse, company-owned vehicles, obvious inventory and busy staff, making the request for current and ex-employees' Social Security numbers more curious indeed.

It is also important to note that during the five months in which the ZPIC conducted a medical necessity review, Medicare held payment on the audited product lines – a practice which has already had severe consequences for smaller providers who cannot withstand the adverse impact on their cash flow. Finally, when Apria brought this matter to CMS' attention, CMS did not participate in a substantive review and discussion of the claims at issue with Apria and the ZPIC but instead advised Apria to appeal the ZPIC's determinations on more than 1,000 dates of service, at significant cost to the government as well as to Apria.

A very high percentage of these appeals will likely be overturned by higher level administrative law judges (ALJs), thus supporting our point that certain aspects of the new audits represent a misapplication of anti-fraud and abuse funds that could otherwise be put to better use either in the area of real-time monitoring of brand new or rapidly-growing Medicare providers or in pursuing truly criminal or potentially criminal providers. Also, by the time the ALJs rule on the appeals, an incorrect error rate will have already been reported to various government officials, thus resulting in potentially misleading and incorrect conclusions, which are rarely, if ever, corrected.

Retroactive Application of Brand-New Auditing Standards is Contrary to Administrative Law Principles

In addition to the burdensome requirements being imposed by the ZPICs and erroneous audit results, Apria is disturbed that CMS' auditors are *retroactively* applying these new auditing standards, contrary to well-established principles of administrative law. The retroactive application includes claims for patients referred to service as long ago as a decade. By its very nature, a rule applies to *future* occurrences. CMS has clearly engaged in retroactive rulemaking with respect to many of its new medical necessity documentation policies and has imposed new documentation policies on claims upon pre- and post-payment review of which DMEPOS suppliers had no prior notice. This is exactly the type of retroactive rulemaking prohibited under *Bowen v. Georgetown University Hospital*, 488 U.S. 204, 208-209 (1988), and its progeny.

It also became clear during a series of conference calls we held with various CMS officials based in Florida and Baltimore that they were unaware of at least some of the ZPICs' practices, thus calling into question whether CMS is appropriately carrying out its oversight responsibilities with regard to its subcontractors' operating policies and procedures. This also leads to inconsistent practices among the various auditing bodies. CMS officials were surprised by some of the data requests being made by the ZPIC subcontractors and asked for more detail to be provided by us so that they could address the behaviors. Yet, most of these processes are not documented in writing anywhere in the Program Integrity Manual, Medicare Learning Matters, Medicare DMEPOS Quality Standards, Medicare DMEPOS Supplier Standards or any other guidance document.

Summary

We conclude by reiterating Apria's absolute support for proper use of Medicare resources to effectively combat fraud, waste and abuse. It is critical, however, that these efforts be rational, balanced and targeted on a "rifle shot vs. shotgun" basis so that legitimate suppliers with a long history of serving the Medicare program are not unduly burdened. As Dr. Peter Budetti said in an interview with Richard Shackelford, President of the American Health Lawyers Association, "Certainly one of our {CMS' Center for Program Integrity} biggest challenges is preventing fraud while not adversely affecting beneficiary access or our partnership with legitimate providers and suppliers" (p. 4, January 2011 issue of *AHLA Connections*). Moreover, in public testimony, the HHS OIG has stated on the record that "[inadvertent] errors do not equal fraud."

We urge Congress and the Centers for Medicare and Medicaid Services to provide needed oversight to the ZPIC process to ensure that real fraud, waste and abuse is targeted and ultimately eliminated.

Respectfully Submitted,

/s/
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